



**DENTAL BOARD OF CALIFORNIA**  
 1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241  
 TELEPHONE: (916) 263-2300  
 FAX: (916) 263-2140  
 www.dbc.ca.gov



To the certifying agency: The dentist requesting license certification is an applicant for a dental license in California based on credentials. Your state's license certification form may be substituted for this form if it includes all of the information requested below. A completed certification form bearing your seal may be sent with any attachments directly to: Dental Board of California, 1432 Howe Avenue, Suite 85, Sacramento, CA 95825-3241. Or you may provide it to the licensee who has made the request.

I hereby certify that \_\_\_\_\_ was issued  
*(name of applicant)*

State Certificate/License Number \_\_\_\_\_ to practice dentistry in the

State of \_\_\_\_\_ on \_\_\_\_\_,

on the basis of: ☐ State clinical examination

☐ Regional clinical examination \_\_\_\_\_  
*(name)*

☐ Reciprocity/endorsement with State of \_\_\_\_\_.

License is ☐ Current, expires: \_\_\_\_\_

☐ Active ☐ Inactive ☐ Expired: \_\_\_\_\_

Has the license ever been disciplined, suspended, revoked, surrendered or otherwise restricted in any way? ☐ Yes ☐ No If yes, provide a copy of the action.

\_\_\_\_\_  
*Signature of State Agency Official*

\_\_\_\_\_  
*Typed Name of State Agency Official*

\_\_\_\_\_  
*Name of State Agency*

(\_\_\_\_\_) \_\_\_\_\_  
*Telephone Number*

\_\_\_\_\_  
*Date of certification*

**STATE SEAL  
 MUST BE AFFIXED HERE**